STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE COURT OF APPEALS)

(Saad, P.J., and Owens and K.F. Kelly, JJ.)

TOD McLAIN, as Personal Representative
of the Estate of TRACY McLAIN, Deceased,

Plaintiff-Appellant,

v

CITY OF LANSING FIRE DEPARTMENT,
CITY OF LANSING, and JEFFREY WILLIAMS,

Defendants-Appellees,

and

MICHAEL DEMPS,

Defendant.
_____/

SC No. 151421
COA No. 318927
LC No. 11-859-NH
(Ingham County Circuit Court)

DEFENDANTS-APPELLEES' SUPPLEMENTAL BRIEF IN OPPOSITION TO APPLICATION FOR LEAVE TO APPEAL

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WHETHER THE HOSPITAL INTERN'S MEDICAL PROGRESS NOTES INDICATING THAT THE PLAINTIFF'S DECEDENT HAD BEEN OBSERVED WITH THE BREATHING TUBE LODGED IN HER ESOPHAGUS WERE ADMISSIBLE EVIDENCE?

Plaintiff-Appellant says "yes."

Defendants-Appellees say "no," with respect to the hearsay statement within the medical progress notes regarding the location of the decedent's breathing tube.

II.

WHETHER THE COURT OF APPEALS CORRECTLY RULED THAT, EVEN IF THE MEDICAL PROGRESS NOTES WERE ADMISSIBLE, THE NOTES WERE INSUFFICIENT TO CREATE A QUESTION OF FACT AS TO WHETHER THE DEFENDANTS WERE GROSSLY NEGLIGENT?

Plaintiff-Appellant says "no."

Defendants-Appellees say "yes."

INTRODUCTION

With the submission of his Supplemental Brief to this Court, Plaintiff has finally backfilled his meager application for leave to appeal and reply brief in support of the application with adequate legal argument and factual support regarding the evidentiary issue in this case. Defendants, who thoroughly briefed the evidentiary issues in its response to the application for leave to appeal, take exception to this legal gamesmanship, and note that a supplemental brief of unlimited length on issues which should have already been briefed in Plaintiff's application briefing provides Plaintiff with an unfair opportunity to make unrebuttable arguments beyond the scope of the traditional reply brief.

That being said, Defendants' response to Plaintiff's application for leave to appeal and the instant supplemental brief address why the medical progress notes (more specifically, the hearsay statement within the progress notes regarding the location of the decedent's breathing tube) are not admissible under any exception to the rule against hearsay, and why, even if the notes are admissible, Plaintiff has still failed to create a genuine issue of material fact regarding whether Defendants were grossly negligent in failing to verify tube placement and monitor the decedent's condition during her ambulance ride. As found by the Court of Appeals, Plaintiff and his expert witness cannot create an issue of fact by simply disbelieving the eyewitness testimony and admissible EMS report indicating that the decedent's condition was properly monitored during her ambulance ride. None of the other admissible evidence in the record suffices to create a genuine issue of fact regarding gross negligence, and thus summary disposition was properly granted to Defendants pursuant to governmental immunity.

SUPPLEMENTAL ARGUMENT I

THE STATEMENT IN THE MEDICAL PROGRESS NOTES INDICATING THE DECEDENT WAS FOUND WITH THE BREATHING TUBE LODGED IN HER ESOPHAGUS IS DOUBLE HEARSAY WHICH IS NOT ADMISSIBLE UNDER ANY EXCEPTION TO THE RULE AGAINST HEARSAY.

1. Plaintiff has waived appellate review of the admissibility of the medical progress note and its statement regarding intubation by failing to properly raise the issue before the Court of Appeals and this Court.

Notwithstanding this Court's February 5, 2016 Order directing the parties to brief the admissibility of the medical progress note (and, by implication, its statement regarding the location of the decedent's breathing tube upon her arrival to the hospital), Plaintiff has waived appellate review of these evidentiary issues by failing to include the issues in his lengthy Statement of Questions Presented in his principal brief on appeal in the Court of Appeals (brief on appeal, pp IV-V), instead providing very limited discussion of the issue in his reply brief in the Court of Appeals (reply brief on appeal, pp 5-6). See *Ammex, Inc v Dep't of Treasury*, 273 Mich App 623; 732 NW2d 116 (2007), app den, 480 Mich 883; 738 NW2d 225 (2007) (appellant waives appellate review of issue by failing to include it in statement of questions presented). Plaintiff likewise failed to include this evidentiary issue in his Statement of Questions Presented on application to this Court (application, p v).

2. The statement regarding intubation is not admissible under MRE 803(6), the business records exception.

In his reply brief in support of his Application for Leave to Appeal, Plaintiff misrepresents to this Court that the Court of Appeals "resolved" the admissibility question regarding the medical progress notes by "noting that the records were admissible under MRE 803(6)" (reply brief on application, p 4). In truth, the Court of Appeals expressly declined to reach the issue of admissibility "because adjudication on the matter is not

necessary to resolve this case," but observed that it was "possible" the medical progress notes were admissible under MRE 803(6) (**Exhibit A**, p 6 fn 8).

The Court of Appeals did not make the fine distinction between the admissibility of the medical progress notes authored by Dr. Post, and the admissibility of the statement within the medical progress notes that the decedent's breathing tube was found in her esophagus upon her arrival to the hospital. The depositions of the decedent's treating physicians at the hospital revealed that no one could determine who was the source of the information in the medical progress notes that the decedent had allegedly been improperly intubated. Dr. Post could not say, without speculating, whether the information had come from Dr. Henney, the patient's family members, or another medical professional (**Exhibit G**, pp 31-32, 35-36, 39). Dr. Henney, who treated the decedent for the first hour of her hospitalization before Dr. Post took over, denied personal knowledge of the fact of the decedent's allegedly improper intubation and also denied being the source of this information in the medical progress notes (**Exhibit F**, pp 41-43, 66).

Although they constitute hearsay under MRE 801(c), hospital records are generally admissible under the business records exception to the rule against hearsay, MRE 803(6). However, a hearsay statement contained within the record itself—"double" hearsay—must be independently evaluated to determine whether that statement is itself admissible as nonhearsay or under an exception to the rule against hearsay. This requirement was illustrated by the Court's analysis in *Merrow v Bofferding*, 458 Mich 617, 626-629; 581 NW2d 696 (1998), of the admissibility of a statement in a plaintiff's medical record regarding the cause of his injuries, where the hospital staff could not establish the source of the statement:

> We note that in this case, the two levels of hearsay consist of (1) the document itself found in the medical record labeled "History and Physical" and signed by Dr. Yasuda, and (2) the statement in the document indicating that the injury occurred after the plaintiff had a fight with his girlfriend.
>
> * * *
>
> The defense, through the testimony of Ms. Leptich, established that the "History and Physical" is a record that is compiled and kept in the regular course of business by the hospital. Consequently, we find that the document itself was admissible under MRE 803(6).
>
> However, not every statement contained within the document is admissible merely because the document as a whole is one kept in the regular course of business. Where, as here, the document contains a contested hearsay statement, a separate justification must exist for its admission, i.e., it must qualify under an exception to the hearsay rule or be properly admissible as nonhearsay.
>
> We conclude that because the second level of hearsay is not justified under an exception to the hearsay rule and *because the defendants failed to lay a sufficient foundation regarding the source of the statement in order to allow its admission under a nonhearsay justification*, the statement concerning the "fight with his girlfriend" was improperly admitted.

458 Mich at 626-629 (footnotes omitted) (emphasis supplied). Here, the statement in the medical progress notes indicating the decedent was found with the breathing tube lodged in her esophagus is double hearsay because it was made out-of-court and is being offered for the truth of the matter asserted, i.e., that the decedent's breathing tube was found in her esophagus when she arrived at the hospital. Therefore, it must be found independently admissible under some exception to the rule against hearsay.

> MRE 803(6) provides:
>
> A memorandum, report, record, or data compilation, in any form, of acts, transactions, occurrences, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or by certification that complies with a rule promulgated by the supreme court or a statute permitting certification, *unless the source of information or the method or*

> *circumstances of preparation indicate lack of trustworthiness*. The term "business" as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

(emphasis supplied). Looking at the statement regarding intubation under MRE 803(6), the statement cannot be found admissible under this rule because "the source of information…indicate lack of trustworthiness," given the fact that Dr. Post, the author of the medical progress notes, cannot identify the source of that statement. In *Merrow*, this Court rejected the argument that the statement in the plaintiff's medical record regarding the cause of his injury could be found admissible under MRE 803(6) where the source of the statement was unknown, because a foundation could not be laid "establishing that the source of the statement was acting in the regular course of business when making the statement." 458 Mich at 627 n 8. Here too, Plaintiff cannot lay the foundation that the source of the statement regarding the decedent's breathing tube was acting in the regular course of business when making the statement, because it is unclear whether the statement was made by a medical professional treating the decedent in the regular course of business. As Dr. Post admitted, the statement could have come from the decedent's husband or daughter, neither of whom would be making the statement in the regular course of business. It is Plaintiff's burden, as the proponent of the evidence, to show that the statement and its source are sufficiently trustworthy for admission under MRE 803(6).

As this Court held in *Solomon v Shuell*, 435 Mich 104, 122-123; 457 NW2d 669 (1990), trustworthiness is not a "mere justification for the admission of evidence otherwise excluded as hearsay," but rather "is itself an express threshold condition of admissibility." The exceptions to the rule against hearsay are rooted in the notion that, under certain circumstances, the trustworthiness of the source of information and the accuracy of

recording is sufficiently great to be the equivalent of a statement given under the ideal conditions of oath, cross-examination, and in the presence of the trier of fact. *Id*. at 119-120, citing 5 Wigmore, Evidence, § 1422, pp 253-254. Looking at the history and evolution of MRE 803(6) and its federal counterpart, the *Solomon* Court noted that the rule empowered and required trial courts to determine whether the sources of information from which the record was made and the method and circumstances of their preparation were such as to indicate their trustworthiness. *Id*. at 124.

Here, the decedent was first treated in the emergency department by Dr. Henney. As the first emergency department physician to treat the decedent upon her arrival, it would be presumed that Dr. Henney would have direct personal knowledge of her condition upon arrival, including whether the tube was found in the decedent's esophagus. The fact that Dr. Henney denies having knowledge of the alleged tube displacement casts strong doubts regarding the trustworthiness of the statement in the medical record regarding the tube. Stated differently, Dr. Henney would be the most trustworthy source of this statement, as he was the treating physician in charge of caring for the decedent upon her arrival to the emergency department. Plaintiff has failed to show that the statement regarding the decedent's tube has a trustworthy source, and thus the statement cannot be admitted under the hearsay exception in MRE 803(6).

2 McCormick on Evidence, § 290 (7th ed.) observes that the language of FRE 803(6) requiring that the record be "made…by—or from information transmitted by—someone with knowledge" means that "the person who originally feeds the information into the process must have firsthand knowledge." MRE 803(6) contains the same language. Here, it is impossible to ascertain whether the person who originally reported to Dr. Post that the

decedent's tube was found in her esophagus had firsthand personal knowledge of that alleged fact. Again, Dr. Henney, who is the individual most likely to have firsthand knowledge of the status of the decedent's intubation upon arrival, denied any knowledge of the tube being displaced. Dr. Post likewise denies any personal knowledge of the tube being displaced. As Plaintiff cannot make the required showing that the statement in the medical record regarding the decedent's tube was made by or from information transmitted by someone with firsthand knowledge of the tube's location upon the decedent's arrival to the emergency department, the statement is inadmissible under MRE 803(6).

3. The statement in the medical record is not admissible under MRE 803(4) as a statement for purposes of medical treatment.

The Court of Appeals did not identify MRE 803(4) as a potential basis for admission of the hearsay statement regarding the tube or the medical progress note itself. As mentioned previously, Plaintiff has waived appellate review of this basis for admission by failing to raise it in his list of Questions Presented before either the Court of Appeals or this Court on application.

MRE 803(4), statements made for purposes of medical treatment or medical diagnosis in connection with treatment, provides for the admission of "[s]tatements made for purposes of medical treatment of medical diagnosis in connection or present symptoms, pain or sensation, or the inception or general character of the cause or external source thereof insofar as reasonably necessary to such diagnosis and treatment."

In his supplemental brief, Plaintiff cites to this Court's opinion in *Merrow*, *supra*, as allowing admission of statements made by unknown declarants under MRE 803(4). This argument is likely taken from the Court of Appeals opinion in *People v Yost*, 278 Mich App

341, 362 n 2; 749 NW2d 753 (2008), where the Court of Appeals *in dictum* opined that the hearsay exception stated in MRE 803(4) "is not limited to statements made by the person being diagnosed or treated." The defendant-appellant in *Yost* did not challenge the propriety of the trial court's ruling to exclude the hearsay statements at issue, made by the child victim's parents and teachers. Id. In opining that the exclusion of the statements was clearly erroneous, the *Yost* panel cited to *Merrow*, 458 Mich at 624, 628-630, as "upholding the admission of a statement in a patient's medical history regarding the cause of an injury even though the medical personnel could not identify the person who provided the history." *Id*.

The *Yost* court's reliance on *Merrow* for this proposition is erroneous and should not be applied to the hearsay statement at issue in the instant case. First, a close examination of the cited portion of *Merrow* reveals that the hearsay statement found to be admissible under MRE 803(4)—that the plaintiff's injury resulted from his arm going through a plate glass window—was not a contested hearsay statement. 458 Mich at 631. In other words, there was no disagreement at trial, from any party, that the plaintiff's injuries were sustained when his arm went through a plate glass window. Thus, the inability of the witnesses to identify exactly who provided that information to the person creating the plaintiff's medical record did not pose a concern about the reliability, trustworthiness and admissibility of the evidence needed to establish that fact. Here, in contrast, the hearsay statement regarding the alleged displacement of the decedent's breathing tube and the alleged duration of the displacement is a highly contested hearsay statement which is critical to establishing Plaintiff's theory of the case, including the opinions of his expert witness. The admission of this hearsay statement is the only way in which Plaintiff would

be able to establish at trial that the decedent's breathing tube was actually dislodged from her trachea at any time during her transport by Defendants to the hospital, as no live witnesses will be able to testify as to their personal knowledge of that alleged fact. In contrast, in *Merrow*, it is more likely than not that multiple witnesses gave fully admissible testimony at trial that the plaintiff's injury resulted from his arm going through the plate glass window. In summary, *Merrow* does not stand for the proposition that a contested hearsay statement from an unknown declarant regarding a patient's medical condition can be found admissible under MRE 803(4), where that statement is the only evidence of a material fact in the case.

4. The statement in the medical progress notes regarding intubation is not admissible in any other form.

Throughout the duration of this case, Plaintiff has attempted to circumvent the inadmissibility of the statement in the medical progress notes regarding intubation by claiming that the statement need not be offered in admissible form in opposition to Defendant's motion for summary disposition See page 4 of Plaintiff's reply brief on appeal, citing MCR 2.116(G)(6) and various cases for the proposition that only the content or substance of documentary evidence proffered to oppose a motion for summary disposition need be in admissible form. While Plaintiff correctly states the rule, he misapprehends its application to the instant case. Here, as previously stated, the medical progress note is the only source of evidence that the decedent arrived at the hospital with the intubation tube inside of her esophagus rather than her trachea. No witness can testify to this fact because no witness has been identified as having personal knowledge of the tube's location upon the decedent's arrival. *Cf. Latits v Phillips*, 298 Mich App 109, 114-115; 826 NW2d 190 (2012) (personal observations of police officers contained in police reports would be

admissible at trial, notwithstanding inadmissibility of the reports, because officers could testify at trial to the substance of the material in the reports). Therefore, it cannot be argued that the alleged evidence of improper intubation would be admissible at trial notwithstanding the inadmissibility of the medical progress notes, such that summary disposition should not have been granted.

SUPPLEMENTAL ARGUMENT II

THE COURT OF APPEALS CORRECTLY RULED THAT EVEN IF THE MEDICAL PROGRESS NOTES WERE ADMISSIBLE UNDER SOME EXCEPTION TO THE RULE AGAINST HEARSAY, THE NOTES WERE INSUFFICIENT TO CREATE A QUESTION OF FACT AS TO WHETHER DEFENDANTS WERE GROSSLY NEGLIGENT.

In his reply brief in support of his application to this Court, Plaintiff admits that his theory of gross negligence is based on Defendants' alleged failure to monitor the decedent's oxygen levels *after* the intubation tube was inserted into her trachea (p 4). According to Plaintiff, "[i]t ultimately makes little difference whether the tube was placed incorrectly or if it was in fact placed correctly but later dislodged. What matters is whether Defendants were appropriately monitoring. They were not" (Id. at pp 4-5). Based on Plaintiff's own admissions, the admissibility of the medical progress notes has no impact on Plaintiff's inability to create a question of fact as to gross negligence because Plaintiff's theory of gross negligence is based *exclusively* on the alleged failure to monitor the decedent's condition, including proper tube placement, during her ambulance ride. As Defendants have stated, the medical progress notes and the statement regarding the intubation tube allegedly being found in the decedent's esophagus establishes only that the tube, at some point, may have become dislodged from her trachea—a fact which, even if established, does not constitute gross negligence by Plaintiff's own admission. *It does not establish that Defendants failed to verify tube placement or otherwise monitor the decedent's condition during her ambulance ride*.

1. The uncontradicted eyewitness testimony of Williams and Murphy established that Defendants took steps to verify proper tube placement and monitor the decedent's condition during her ambulance ride.

Defendants provided ample admissible evidence of their efforts to verify proper tube placement and monitor the decedent's condition during her ambulance ride. Defendants Williams and Murphy provided eyewitness testimony in their depositions and their written Prehospital Care Report (admissible under MRE 803(6)) that the team members visually verified tube placement in the trachea and monitored for tube misting, chest rise, lung sounds, and the absence of abdominal distension:

> Q. When it says "Recheck – Patent," I know what the word "patent" means. What is the "recheck" supposed to be?
>
> A. Basically, it's continuous monitoring of the chest rise and the abdomen not rising and mist in the tube. It's a patent airway so you're continuously monitoring that.
>
> Q. Okay. And if it says "Patent," it means it's obvious you could see that all those were happening; is that a fair understanding?
>
> A. It's fair.
>
> * * *
>
> Q. So you had the continuous monitoring, the chest rise, the abdomen not rising, and the moisture in the tube?
>
> A. Yes.

(**Exhibit C**, pp 77-78).

> Q. Okay. Did you check for an improper intubation while Ms. McLain was in the ambulance?
>
> A. Yes.

(*Id.* at 102).

> A. I don't believe she died because of esophageal intubation by Jeff Williams because there's—it would be impossible to bag for five minutes or whatever our transport time was without gastric distension or regurgitation. She would have vomited out of that tube into the bag valve mask—

Q. Okay.

A. --and then I would have pushed Jeff Williams aside and I would have reintubated myself.

(**Exhibit B**, p 91). The testimony of Williams and Murphy shows that while their recall of events was not perfect, it was sufficient to establish the trustworthiness under MRE 803(6) of the activities recorded in the Prehospital Care Report as part of the ordinary course of Defendants' business. Williams remembers intubating the decedent and remembers that one of the team members checked for chest rising, lung sounds and tube misting during the short ride to the hospital (**Exhibit C**, pp 71-83, 90-92, 97, 99-101). Murphy, drawing on 20 years of experience, does not remember any inappropriate care or problems with the intubation performed by Williams and relied on the detailed report written by Williams as to the specifics of the care provided (**Exhibit B**, pp 60-63). Plaintiff's EMT expert Robert Krause admitted that he would rely on a written report rather than his own memory as to an ambulance run which occurred over two years ago (**Exhibit O**, Krause deposition, p 86).

2. Plaintiff expert Krause's opinions are insufficient to prevent summary disposition because they lack sufficient foundation or are inconsistent with established facts.

The Court of Appeals correctly found that Krause's expert opinion cannot create a material factual dispute regarding Defendants' monitoring of the decedent's condition because it is based on disparaging the eyewitness testimony of Williams and Murphy and the other record facts in evidence (**Exhibit A**, p 6). Krause's deposition and affidavit of merit are replete with statements disagreeing with Williams and Murphy's personal observations of the decedent's care, both as recalled by their respective memories at the time of their depositions and as recorded in the Prehospital Care Report:

- Krause disagrees that proper intubation was verified using observations and lung sounds, even though Williams testified he observed another paramedic watching the decedent and listening for lung sounds as he intubated her, and did not see regurgitation indicating improper tube placement (**Exhibit C**, pp 77, 99-100) (**Exhibit O**, pp 82, 85);
- Krause alleges Defendants failed to continuously monitor the decedent's condition, even though Williams testified the decedent was monitored throughout her ambulance ride for tube misting, chest rise and abdominal distension (**Exhibit C**, pp 77, 83-84) (**Exhibit K**, ¶ 11D);
- Krause admits the absence of a notion of abdominal distension in the Prehospital Care Report is consistent with the hospital record noting no abdominal distension, but still claims that Williams was grossly negligent for failing to note abdominal distension if it was present (**Exhibit O**, pp 87-88, 90-91) (**Exhibit K**, ¶ 11A);
- Krause admits there is nothing in the Prehospital Care Report or Williams' testimony to indicate that Williams "willfully misreported tube misting where the intubation was done incorrectly" (**Exhibit K**, ¶ 11A) (**Exhibit O**, pp 87-90);
- Williams had a personal recollection of responding to the call and intubating the decedent (**Exhibit C**, pp 58, 71-72);
- Although Krause alleges Williams failed to visualize intubation into the trachea (**Exhibit K**, ¶ 11E), Krause admitted Williams testified that he visualized the intubation into the trachea by using a laryngoscope, and that he was able to visualize the intubation because there was no vomit present (**Exhibit C**, pp 71-72) (**Exhibit O**, pp 94-95);
- Krause acknowledged that it was possible Williams did not have a personal recollection of all aspects of the decedent's care at the time he was deposed over two years later, and admitted that he himself would rely on his patient care report rather than his own memory in those circumstances (**Exhibit O**, p 86).

An expert witness's attempt to create a material issue of fact by merely disparaging the record evidence, including the eyewitness's powers of observation, was rejected by the Court of Appeals in *Badalamenti v William Beaumont Hospital,* 237 Mich App 278, 286; 602 NW2d 854 (1999), and should likewise be rejected by this Court with respect to Krause's opinions. In *Badalamenti*, the plaintiff's expert based his opinion that the plaintiff was in cardiogenic shock on his "skepticism" of the echocardiogram performed by one of the plaintiff's treating doctors, and his unwillingness to accept that doctor's finding that the wall function of the plaintiff's heart was nearly normal. *Id.* at 287. The Court of Appeals

reversed the jury's verdict, finding that the expert testimony was "legally insufficient" to support the plaintiff's theory because there was no reasonable basis in evidence to support his opinion, which was based only on his skepticism and disparagement of the treating doctor's findings. *Id.* at 288-289. Krause's opinions in this case are no better than those found legally insufficient in *Badalamenti*, as they rely only on his skepticism and disparagement of the treating paramedics' observations of the decedent's intubation. See **Exhibit T**, p 6.

Assuming *arguendo* the medical progress notes and the statement regarding intubation are admissible, given the admissible testimony and documentary evidence of Defendants' actions to verify proper tube placement and monitor the decedent's condition during her ambulance ride, nothing in the trial court record, including the medical progress notes and the expert opinions of Krause, creates a material factual dispute or a credibility contest barring summary disposition as to gross negligence.

3. The decedent's blood gas values, the affidavit of merit of Dr. Bowles, and the Life Support Manual do not help Plaintiff establish gross negligence or willful misconduct.

Plaintiff argues that in addition to the inadmissible statement in the Hospital Record regarding an improper intubation and Krause's opinions on the standard of care, gross negligence and/or willful misconduct can be established using Plaintiff's blood gas values, the causation affidavit of merit submitted by Dr. Bowles, and the American Heart Association's Advanced Cardiovascular Life Support Provider Manual (Plaintiff's brief on application, pp 19-21). None of these meets Plaintiff's burden under MCR 2.116(C)(7) to show facts in avoidance of immunity under the EMSA.

Plaintiff relies on arterial blood gas values drawn from the decedent which Krause asserts show the decedent was acidotic (indicating hypoxia from improper tube placement) when she arrived at the hospital (**Exhibit O**, pp 41-43).[1] However, this bloodwork was drawn at 10:15 p.m., after the decedent had been treated at the hospital for nearly two hours, had been given additional medications, and was on a ventilator. The bloodwork drawn earlier at 8:40 p.m.—shortly after the decedent's arrival at the hospital—showed her arterial blood gas pH to be 7.31, within what Krause testified was "normal" range (Plaintiff's Exhibit I, p 2) (**Exhibit O**, p 41). Even assuming *arguendo* the decedent was acidotic at any time, Krause admits that her underlying hypoxic condition was caused by her asthma attack (**Exhibit O**, pp 36, 38-39). Defendants' EMT expert Gregory Hammond testified that he has seen severely asthmatic patients like the decedent die even when properly intubated (**Exhibit R**, p 171). Thus, the decedent's allegedly acidotic state two hours after her arrival at the hospital is not reliable evidence that she was improperly intubated on her way to the hospital.

Plaintiff's "key circumstantial evidence" that the decedent's oxygen levels "rebounded" after her reintubation at the hospital does not create an issue of fact as to gross negligence because, as the trial court noted, this at most only constitutes evidence of a failed intubation or a dislodged tube, which is insufficient to establish gross negligence (**Exhibit L**, pp 23-24). Plaintiff has provided no evidence establishing that the oxygen levels could have rebounded *only* if the breathing tube had been lodged in the esophagus

[1] Defendants argued below that Krause, an EMT, was not qualified to render opinions regarding the clinical significance of blood gas values (See Defendants' brief in support of summary disposition, p 14).

unnoticed for five minutes, rather than following a brief dislodging of the tube upon her transfer from the ambulance into the hospital.

Plaintiff asserts that he will rely on the testimony of pulmonologist Dr. Bowles to establish that if the decedent would have been properly intubated, she more likely than not would have lived and not suffered brain damage (Plaintiff's application brief, p 22). There are several problems with this argument. First, as the trial court noted, the testimony of Plaintiff's causation expert Dr. Bowles cannot be used to save or bolster the inadequate testimony of Plaintiff's standard of care expert Krause (**Exhibit L**, p 29). Dr. Bowles has no experience with the duties or standard of care for EMTs. Second, and more fundamentally, Plaintiff's preview of Dr. Bowles' testimony shows that it too is inconsistent with the established facts in the case. Again, this stems from the unsupported premise that the decedent was improperly intubated by Williams. Although Williams testified that he properly visualized the intubation into the trachea, Dr. Bowles will apparently testify that if Williams had actually been looking and had rechecked his visualization, he would have realized that the tube was actually in the esophagus (*Id.* at 30-31). According to Plaintiff, this testimony will challenge Williams' credibility and allow the jury to conclude that "he's not telling the truth" (*Id.* at 31). Dr. Bowles is no better qualified than Krause to dispute the eyewitness testimony and recollection of Williams and Murphy as to what happened in the ambulance, as recorded in the Prehospital Care Report. Third, Plaintiff cannot avoid summary disposition by promising, without any corresponding statements in the affidavit of merit, that Dr. Bowles will testify at trial that proper tube placement does not correlate to the oxygen saturation readings shown in Williams' charting (Plaintiff's brief, p 21). Plaintiff's mere promise to produce admissible evidence creating an issue of fact for trial is

insufficient to survive summary disposition—the evidence must be produced in response to the summary disposition motion for consideration by the trial court. *Maiden*, 461 Mich at 121.

As for the American Heart Association manual (**Exhibit S**), it merely shows that hypoxia is linked to PEA. As discussed above, the decedent's hypoxia (and corresponding PEA) was also attributable to her severely asthmatic state, which Defendants did not cause. Williams' denial of a link between improper intubation and PEA, even if incorrect, has nothing to do with his testimony regarding the care rendered to the decedent, including the Prehospital Care Report showing the measures taken to verify proper intubation.

4. Williams' failure to use capnography and colorimetric tools to verify intubation did not constitute gross negligence.

Krause and Plaintiff allege Williams was grossly negligent because he failed to use capnography and colorimetric tools to verify proper placement of the tube (**Exhibit K**, ¶¶ 11B-C) (**Exhibit I**, ¶¶ 39B-C). However, Krause admits that capnography technology was not available for Williams to use in 2009, and further admits that he did not know whether colorimetric tools were available on the particular ambulance used to transport the decedent (**Exhibit O**, pp 91, 92) (**Exhibit C**, p 44). Williams cannot be found grossly negligent for failing to use equipment which was not available to him. Moreover, even if colorimetric tools might have been available, the fact that the decedent's breath sounds were checked in all four quadrants of her lungs and proper intubation was otherwise verified mitigates any effect the use of this tool may have had on the outcome of her condition (**Exhibit C**, pp 74-75).

The fact that the decedent's breath sounds were checked and were positive for proper intubation also mitigates the Defendants' alleged failure to check the decedent's oxygen levels every five minutes during her nine-minute ambulance ride. Defendants' EMT expert Gregory Hammond was not critical of Defendants for failing to serially check the decedent's pulse oximetry levels on the way to the hospital because the five-minute serial vital signs check guideline suggested by the American Heart Association is predicated upon six caregivers being around the patient's side, rather than the three present in this case to care for a patient already in full cardiac arrest (**Exhibit R**, Hammond deposition, pp 102-104, 174). He also noted that a pulse oximetry reading is slow to respond to treatment (*Id.* at 102).

5. Response to factual allegations in Plaintiff's supplemental brief.

A response is necessary to several of the factual allegations which Plaintiff contends, in his supplemental brief, support a finding of gross negligence. First, Plaintiff quotes extensively from the deposition testimony of Plaintiff, the decedent's husband, regarding his alleged conversations with Dr. Kowalczyk, who did not begin treating the decedent until two days after her admission to the hospital. Specifically, Plaintiff testifies in his deposition that Dr. Kowalczyk informed him that the decedent had been improperly intubated by Defendants, and that this caused her death (**Exhibit F** to Plaintiff's application, pp 42-43). This testimony is blatant hearsay, which Plaintiff has not shown to be admissible under any exception to the rule against hearsay. Dr. Kowalczyk was deposed in this case and could not remember if he told Plaintiff there was an improper intubation (**Exhibit V**). Dr. Kowalczyk assumed Dr. Henney was the source of the statement in the decedent's medical

records regarding the tube placement; again, Dr. Henney denies any knowledge of this alleged fact (Id. at 35).

Second, given the absolute lack of any evidence of abdominal distention, Plaintiff cannot avoid summary disposition by claiming simply that Williams must have been grossly negligent because he failed to document signs of abdominal distention which Plaintiff asserts, without any support in the record evidence, were visible due to the decedent's allegedly improper intubation (supplemental brief, p 13). Dr. Kowalczyk confirmed that the hospital records showed no sign of abdominal distention upon the decedent's arrival to the hospital, which he would have expected to see if the breathing tube had been lodged in her esophagus for five minutes (Id. at 35-36).

Third, Plaintiff's assertion that Williams falsified the Prehospital Care Report to reflect that he verified proper tube placement and monitored the decedent's condition only after he had "full knowledge of the disastrous outcome" is an outrageous and unsupportable allegation wholly devoid of any support in the record. There is absolutely no evidence that Williams or any of the other Defendants had knowledge of the decedent's condition after handing her over to the emergency department staff. The decedent was found at her home in *status asthmaticus*, remained in that severe condition throughout her nine-minute ambulance ride, and further remained in that condition *for two days* after being admitted to the hospital (**Exhibit V**, p 30). The unsupported accusation that Williams deliberately falsified the Prehospital Care Report within the two hours after the decedent arrived at the hospital based on an allegedly "disastrous outcome" which had not yet occurred, i.e., the decedent's death, is beneath the dignity of this Court and of Plaintiff's counsel.

6. Even if accepted as true, the allegations in Plaintiff's complaint do not rise to the level of gross negligence.

In *Maiden v Rozwood*, 461 Mich 109, 122; 597 NW2d 817 (1999), this Court defined gross negligence for purposes of governmental liability as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." Importantly, "evidence of ordinary negligence does not create a material question of fact concerning gross negligence." *Id.* A determination by this Court as to whether Plaintiff can create a genuine issue of material fact as to gross negligence requires this Court to determine whether, assuming that Plaintiff can proffer admissible evidence of the allegations in her complaint, the allegations themselves—that Defendants failed to verify intubation and to monitor the decedent's vital signs and oxygen levels during her ambulance ride—legally rise to the level of gross negligence rather than ordinary negligence.

Since this Court's pronouncement in *Jennings v Southwood*, 446 Mich 125, 128; 521 NW2d 230 (1994) that the gross negligence standard applies to EMSA cases, there have been only two published opinions from our appellate court, including the instant case, applying the new definition of gross negligence in the context of the EMSA (there have been numerous unpublished opinions). *Costa v Community Emergency Medical Services, Inc*, 263 Mich App 572; 689 NW 2d 712 (2004), the plaintiffs alleged that the defendant paramedics were grossly negligent in the following manner:

> 1. *Failure to assess vital signs*;
>
> 2. Failure to conduct a physical examination of the patient while he remained unconscious;
>
> 3. On regaining consciousness, failure to properly assess the patient's competence to refuse treatment;

4. Failing to explain to the patient the potential consequences of his refusal of treatment; and

5. Failing to transport the patient to the hospital.

Costa, 263 Mich App at 578 (emphasis supplied). The Court of Appeals in *Costa* reversed the lower court's refusal to grant summary disposition, finding that the acts and/or omissions alleged against the defendant paramedics did not rise to the level of gross negligence as defined under the EMSA. *Id*. at 579. In doing so, the Court of Appeals quoted this Court's decision in *Maiden* for the proposition that "[e]vidence of ordinary negligence does not create a material question of fact concerning gross negligence." *Costa* at 578, quoting *Maiden* at 122-123. Further, in dismissing the case against the pre-hospital care providers, the *Costa* panel pointed out that the plaintiff's references in the complaint to "gross negligence" were insufficient to establish a claim of gross negligence, where the allegations and proofs sounded only in ordinary negligence. *Costa*, *supra* at 579.

Although the Court of Appeals has addressed many civil appeals in the context of the EMSA through unpublished opinions, it is important to emphasize that *only one Michigan appellate decision has found gross negligence to exist under the definition of that term as declared by this Court in Jennings*.[2] Of particular relevance to this case are the following two opinions, in addition to *Costa*:

- *Herrington v LifeCare Ambulance*, Court of Appeals Docket No. 263583, *rel'd* January 24, 2006; 2006 WL 170663 (unpublished) (failure by paramedics to manage

[2] In *Soffin v City of Livonia Fire and Rescue Dep't*, Court of Appeals Docket No. 219880, *rel'd* July 3, 2001; 2001 WL 753891 (unpublished), the Court of Appeals found a question of fact existed as to whether EMTs who arrived first on the scene to treat a woman exhibiting signs of shock and did nothing until another ambulance arrived were grossly negligent in their evaluation of the seriousness of the plaintiff's medical condition.

asthmatic patient's airway, including failure to confirm tube placement, does not constitute gross negligence under EMSA); and

- *Castle v Battle Creek Area Ambulance*, Court of Appeals Docket No. 277068, *rel'd* March 19, 2009; 2009 WL 725924 (unpublished) (failure by paramedics to intubate patient after noticing patient had stopped breathing does not constitute gross negligence under EMSA).

These opinions collectively suggest that, even if Plaintiff could submit admissible evidence that Defendants failed to monitor the decedent's vital signs or her oxygen levels during her ambulance ride to verify proper intubation, those alleged omissions would constitute only ordinary negligence failing to create a genuine issue of material fact as to gross negligence under the EMSA. There simply are no facts to indicate the type of reckless conduct that demonstrates the "substantial lack of concern" for an injury required to demonstrate gross negligence. It also bears mentioning that the opinions of Plaintiff's expert to the effect that the standard of care was violated does not constitute a question of fact as to whether there was gross negligence. For these reasons, the trial court and the Court of Appeals acted properly in ruling that Defendants were entitled to summary disposition as a matter of law on the question of gross negligence.

CONCLUSION AND RELIEF REQUESTED

WHEREFORE, Defendants-Appellees request this Court deny leave to appeal, affirm the March 3, 2015 decision of the Court of Appeals, deny Plaintiff's requested relief, and grant all other relief deemed appropriate, including costs so wrongfully sustained in defending this matter on appeal.

Respectfully submitted,

By: /s/Robert G. Kamenec

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Dated: April 1, 2016

STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE COURT OF APPEALS)

(Saad, P.J., and Owens and K.F. Kelly, JJ.)

TOD McLAIN, as Personal Representative
of the Estate of TRACY McLAIN, Deceased,

Plaintiff-Appellant,

v

CITY OF LANSING FIRE DEPARTMENT,
CITY OF LANSING, and JEFFREY WILLIAMS,

Defendants-Appellees,

and

MICHAEL DEMPS,

Defendant.
_____/

SC No. 151421
COA No. 318927
LC No. 11-859-NH
(Ingham County Circuit Court)

PROOF OF SERVICE/STATEMENT REGARDING E-SERVICE

STATE OF MICHIGAN)
)SS
COUNTY OF INGHAM)

ROBIN LARSON, being duly sworn, deposes and says that she is an employee of the law firm of Plunkett Cooney, and that on April 1, 2016, she caused to be served, a copy of a Defendants-Appellees' Supplemental Brief in Opposition to Application for Leave to Appeal, and Proof of Service/Statement Regarding E-Service, as follows:

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Counsel was served via TrueFiling

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/s/Robin Larson
ROBIN LARSON

Open.18566.33117.16741262-1

STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

TOD McLAIN, as Personal Representative
of the Estate of TRACY McLAIN, Deceased,

Plaintiff-Appellant,

v

CITY OF LANSING FIRE DEPARTMENT,
CITY OF LANSING, and JEFFREY WILLIAMS,

Defendants-Appellees,

and

MICHAEL DEMPS,

Defendant.
_____/

SC No. 151421
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INDEX OF EXHIBITS TO DEFENDANTS-APPELLEES' SUPPLEMENTAL BRIEF IN OPPOSITION TO PLAINTIFF-APPELLANT'S APPLICATION FOR LEAVE TO APPEAL*

EXHIBIT	DESCRIPTION
A	Hospital Record dictated by Dr. Joel Post
B	April 10, 2012 deposition of Captain Margaret Murphy
C	April 6, 2012 deposition of Jeffrey Williams
D	Prehospital Care Report written by Jeffrey Williams
E	April 6, 2012 deposition of Michael Demps
F	August 24, 2012 deposition of Dr. Jason Henney
G	July 9, 2012 deposition of Dr. Joel Post
H	Transcript of June 20, 2012 hearing on motions for summary disposition

*Exhibits A-U were previously filed with Defendants' Response to Plaintiff's Application for Leave to Appeal.

I	Plaintiff's First Amended Complaint
J	First Amended Affidavit of Merit as to Causation Only by Dr. Alvin Bowles
K	First Amended Affidavit of Merit by Robert Krause
L	Transcript of September 25, 2013 hearing on Defendants' motion for summary disposition
M	October 16, 2013 Order Granting Defendants' Motion for Summary Disposition
N	June 29, 2012 Order Granting in Part and Denying in Part Plaintiff's Motion for Summary Disposition
O	March 11, 2013 deposition of Robert Krause
P	January 23, 2013 deposition of Lt. James Garlitz
Q	*Green v Henry Ford Wyandotte Hosp*, Court of Appeals Docket No. 310768, *rel'd* February 11, 2014; 2014 WL 547610
R	March 22, 2013 deposition of Gregory Hammond
S	American Heart Association's Advanced Cardiovascular Life Support Provider Manual
T	March 3, 2015 Court of Appeals opinion
U	House Legislative Analysis, HB 5063 and 5803, October 25, 2000
V	July 31, 2012 Deposition of Dr. Michael Kowalczyk

*Exhibits A-U were previously filed with Defendants' Response to Plaintiff's Application for Leave to Appeal.

EXHIBIT V

MCLAIN v. CITY OF LANSING FIRE DEPARTMENT, ET AL

MICHAEL KOWALCZYK, D.O.

July 31, 2012

Prepared for you by

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

TOD McLAIN, Personal Representative
of the Estate of TRACY McLAIN, Deceased,
Plaintiff,
vs. Case No. 11-859-NH
Hon. Paula J.M. Manderfield
CITY OF LANSING FIRE DEPARTMENT,
CITY OF LANSING, JEFFREY WILLIAMS
and MICHAEL DEMPS,
Defendants.
_____

The Deposition of MICHAEL KOWALCZYK, D.O.,
Taken at 120 North Washington Square, Suite 805,
Lansing, Michigan,
Commencing at 10:08 a.m.,
Tuesday, July 31, 2012,
Before Becky L. Johnson, CSR-5395.

APPEARANCES:

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EXHIBITS

Lansing, Michigan
Tuesday, July 31, 2012
10:08 a.m.

MICHAEL KOWALCZYK, D.O.,
was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

MR. ROSENBERG: Good morning, Doctor, how are you?

THE WITNESS: Good.

MR. ROSENBERG: My name is Eric Rosenberg, we met just before the deposition started, I am the attorney for the Estate of Tracy McLain. My client is Tod McLain. Following the passing of Mrs. McLain Tod McLain asked a court to make him the personal representative of her estate, the court did so and Mr. McLain then hired my office and I'm taking this deposition today along with defense counsel, Ms. Folino, in conjunction with the case so I wanted to start out with that.

I'm going to go through, Doctor, a few formalities. I'm going to try to keep them as short as I can, but I do like to make sure we all understand

what the guidelines are, would that be okay with you?
THE WITNESS: Yes.
MR. ROSENBERG: I absolutely want to tell you I understand you're a physician, if you have a call you need to attend to, please let us know. If your phone goes off or something we'll go off the record and we'll wait. Your patients and your practice come first so I want to make sure you're comfortable. If you need to take a phone call or make one please let us know, we'll stop what we're doing, is that okay with you?
THE WITNESS: Yes, but -- off the record?
MR. ROSENBERG: Sure.
(Discussion off the record at 10:09 a.m.)
(Back on the record at 10:12 a.m.)

EXAMINATION

BY MR. ROSENBERG:

Q. So, Doctor, I'm going to be going through some guidelines. As I say, I'll move as quickly as I can. I understand -- if you don't need to take a call, fine, but if you do for whatever reason that comes up please let us know.
Would you please spell your last name for us just for the record?

A. K-O-W-A-L-C-Z-Y-K.

Q. Okay. And what is a good address for you, Doctor?

A. 3955 Patient Care Drive, Lansing.

Q. Okay. ZIP code?

A. 48911.

Q. And what's a working phone number for you just so we have it for the record?

A. (517) 374-7600.

Q. Okay. Has your deposition ever been taken before?

A. Yes.

Q. Do you know how many times?

A. Ten.

Q. Okay. Any in the last year?

A. No.

Q. Okay. As I said, I'm going to just run through a few things, you may have heard them before in previous depositions, I'll try to move as quickly as I can but in order to protect our record here I do need to go through a few things, so please bear with me. You've probably heard some of it, if not all of it, before.
I do need to state that this is a deposition that can be used for all permissible purposes under the Michigan Court Rules and the Michigan Rules of Evidence.
To your left and my right is a court reporter, her job is to take down the questions, the

answers, any objections, et cetera that go on today so it's not quite a normal conversation, Doctor, in that you and I both have to yield when the other one is talking. And I don't say that because I'm a politeness guru, I do it because our court reporter can take down one set of comments. I will do my level best when you're talking not to interrupt you. If I break that it is by accident and I apologize. Similarly, if you do that by accident and someone says just one at a time, please don't be offended, that's just the way the business works. Does that make sense?

A. Yes.

Q. Okay. If you do not understand a question please let me know, if I don't hear -- if I don't have any question of your understanding I'm going to assume that you did understand the question. Similarly, if you're not sure of an answer I don't want you to speculate, but sometimes people say oh, I think but I'm not sure. It's important to say it that way because if I don't hear that I'm going to assume that you were certain of what you were saying, does that make sense?

A. Yes.

Q. Okay. The usual, please do not nod your head as an

answer because, again, the court reporter needs a verbal answer. Don't speak too fast or too slow. Yes should be yes, not uh-huh, and no should be no, not huh-uh, and I have the same bad habit as everyone else so if we do it our court reporter will correct us, okay?

A. Yes.

Q. Okay. And you don't have this issue, I can tell already. My wife will tell me I'm way too loud so I don't have the problem of talking too quietly sometimes, but if someone asks you to speak up please, again, don't be offended, it just means the court reporter has to be able to take down what you're saying.
If you need a break for any reason or also Ms. Folino or the court reporter, let me know. This is not like law on TV, we're just two lawyers here trying to get some information from someone who saw a patient potentially, that's it. From time to time one of the lawyers may object, Ms. Folino may object for one of my questions, I may object for one of hers. When lawyers are objecting my request is respectfully just don't say anything, let the lawyers work it out, we'll instruct you if you can answer. Oftentimes you can, if there's an issue where you can't we'll let you

know.

Sometimes I may go to ask a question and I may strike it. It will happen several times today, it usually does. Either I didn't like my question or I realized you've answered it or I'm out of order. If I strike the question, no need to answer it. Any questions so far, Doctor?

A. No.

Q. Okay. Did you bring any documents with you today related to this case?

A. No.

Q. Okay. Did you review -- and I know we spoke off the record with Ms. Folino, myself and you, and you said you briefly reviewed some sort of record or another. What did you review in anticipation of this deposition?

A. The EMR from Ms. McLain's hospital stay in 2009.

Q. Okay. And EMR, is that an emergency medical record?

A. No, the electronic medical record.

Q. Thank you, thank you, electronic medical record, okay. Did you review anything else in conjunction with today's deposition?

A. No.

Q. And I know you said this already off the record but I need to get it on the record, have you had -- other

than receiving a subpoena have you received any kind of communication from my office regarding this matter?

A. No.

Q. Okay. And other than -- strike the question.

Did you receive any communication from defense counsel's office with regard to this deposition?

A. No.

Q. Okay. You had mentioned, again, as we were talking off the record that you currently are in private practice. What is the name of your practice, Doctor?

A. Capital Internal Medicine Associates.

Q. What city is that in?

A. Lansing.

Q. Okay. When did you start working for Capital Internal Medicine Associates?

A. We formed in 1994.

Q. When you say we, are you one of the owners?

A. Yes.

Q. Okay. And that's where you've worked since 1994 I assume?

A. Yes.

Q. Okay. All right. I'm going to try in the course of the morning to -- not only that you get out at a reasonable time, but also to be fair to you to weave

in and out as little as possible; in other words, the specific incidences involving my client's wife versus other times, I'll try to not go back and forth more than necessary. Sometimes I'll do a bit of that in time. I'll try to make clear when I'm doing it and I'll try to do it as little as possible, if that's all right with you?

I do want to go back now and get some of your background so I have that. Where did you earn your bachelor's from college?

A. Michigan State University.

Q. What year?

A. 1982.

Q. Okay. All right. And did you then go on to medical school?

A. No, I worked for two years --

Q. Okay.

A. -- at Hazleton Laboratories in Virginia --

Q. What did you do there?

A. -- in Reston, Virginia.

Q. I'm sorry, I didn't mean to interrupt you. What did you do there?

A. I was a lab technician.

Q. And so you commenced medical school 1984?

A. Yes.

Q. Okay. Where did you go?

A. Michigan State University College of Osteopathic Medicine.

Q. All right. And did you go full time while you were there?

A. Yes.

Q. When did you graduate?

A. 1988.

Q. Okay. I'm assuming a D.O.?

A. Yes.

Q. Okay. While you were at MSU before you graduated did you do any kind of work in a medical facility?

A. Yes.

Q. Where did you work?

A. I worked at Lansing General Hospital.

Q. Do you remember the years?

A. 1984 to 1988.

Q. Okay. And what did you do?

A. An orderly.

Q. Okay. Was that -- I'm assuming that was part time given you were going to school?

A. Yes.

Q. So you graduated in 1988 with a D.O., what did you do then?

A. Internship at Lansing General Hospital.

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Q. Is that '88 to '89?
A. Yes.
Q. Okay. Then did you have a residency after that?
A. Yes, internal medicine.
Q. Same place?
A. '89 to -- yes, '89 to '92.
Q. Okay. Help me out, if you can, because I don't know exactly, when would the boards have fit in for -- your medical boards with your residency, before, after?
A. After.
Q. Okay. When did you take your boards?
A. 1992.
Q. And which -- do you remember, which one was it?
A. The internal-medicine boards.
Q. Okay. I'm assuming you passed on the first try?
A. Yes.
Q. Okay. Is that one where you have to renew every X numbers of years?
A. No, because I'm old enough that I've grandfathered in.
Q. Okay. So you've been continuously certified by that board since passing in 1992?
A. Yes.
Q. Okay. What states are you licensed to practice medicine?
A. Michigan.

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Q. What year was that that you first got licensed?
A. 1989.
Q. And licensed continuously ever since?
A. Yes.
Q. Okay. Have you been licensed previously in any other state?
A. No.
Q. Okay. Did you graduate with some -- by the way, some kind of honors from the osteopathic school --
A. No.
Q. -- in 1988?
Okay. Do you remember your percentile in the class? If you don't, you don't.
A. It was in the 90 percentile.
Q. Okay. I'm impressed. I don't think I'd get into the 50 in an osteopathic medicine school, but that's neither here nor there, I am impressed. You left in -- strike the question.
Have you done any other kind of fellowship or formal education since then?
A. No.
Q. Okay. Any sub-certifications that you've gotten through the internal-medicine boards or no?
A. No.
Q. Okay. In 1992 when you concluded your residency where

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did you then go to work?
A. In Eaton Rapids.
Q. Doing what?
A. I worked in practice with another physician.
Q. Okay. For how long?
A. I did that for probably four years, then I also worked in Lansing with Dr. Dehlin.
Q. Can you spell that for me, please?
A. D-E-H-L-I-N.
Q. About what years with Dr. Dehlin in Lansing, if you know?
A. From January of '93 until present.
Q. Is the -- strike the question.
Did the working with Dr. Dehlin lead to that business you set up in 1994?
A. Yeah, we formed it in 1994.
Q. Okay. What hospitals, if it's not a long, long list, are you -- do you have admitting privileges at? If it's a long list, tell me that.
A. Nope, McLaren, Greater Lansing, Sparrow and I think that's it now.
Q. Would that -- to the best of your knowledge was that true in 2009 as well as today?
A. Yes.
Q. Okay. And McLaren used to be Ingham Regional is my

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understanding?
A. Yes.
Q. Okay. In the -- strike the question.
Do you ever get called in to work regular shifts at what's now McLaren Hospital?
A. I work every day there.
Q. At McLaren?
A. Yes.
Q. And was that true in 2009 as well?
A. Yes.
Q. Okay. Can you explain for me, and I'm sure it's probably an easy explanation, you have a practice with someone but you're at McLaren every day, is your practice entirely done out of McLaren?
A. No, I have an office practice also.
Q. Okay. About how many hours a day on average would you say you're at McLaren?
A. It's variable, like some days maybe 4 hours a day, other days 15 hours a day.
Q. Okay. When you're working at McLaren is that still in conjunction with your being part of Capital Internal Medicine Associates?
A. Yes.
Q. Okay. So McLaren has some sort of arrangement with Capital Internal Medicine Associates that has you

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there for some number of hours during the day?
A. Yes.
Q. And that was true in 2009 as well?
A. Yes.
Q. Okay. I do want to state if I ever, I probably will once or twice, if I ever mischaracterize your testimony it is completely an accident, it is benign, feel free to let me know I have it wrong. It's totally because I'm trying to read my chicken-scratch notes and at the same time pay close attention to you, so I'm sorry if I mischaracterize anything, it is totally an accident.
A. It looks like you write better than most doctors probably.
Q. I'll take that as a compliment. I don't know if my secretary would agree with you, she might not.
A. I'm looking at it upside down though.
Q. It looks upside down to me and I'm looking at it, but I appreciate that and I do try to keep my focus on your answers rather than on simply my notes.
Do you know, just so I understand, in advance of a week -- say on a Sunday do you know what hours you'll be at the hospital each day that week or you have no idea until the day of?
A. No, no.

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Q. Okay. You must work a lot of hours in a week?
A. Yes.
Q. I had a feeling. I know you've testified that you looked at the electronic medical record for Ms. McLain, I'm going to ask you a few questions that revolve around what you remembered before and then what you remembered after. And I may do that a few more times today so I just want to tell you if I do that it is just to understand what you remembered before being refreshed and then if you got refreshed by anything.
Before you opened up any record on Ms. McLain, you received a subpoena, you received a check, a request to be here today, you made your arrangements for work, whatever it is you have to do, did you remember who Tracy McLain was?
A. Yes.
Q. Okay. At that point, prior to looking at any records, what did you remember about Tracy McLain?
A. That she unfortunately passed away while we were caring for her.
Q. Okay. Did you remember some specifics about her before you looked at the chart?
A. I remembered her husband quite well.
Q. What do you remember about her husband?

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A. He was -- he was -- I mean, he was just -- I just remember he was there quite a lot so we talked quite a lot.
Q. Good way you remember him, bad way, middle of the road?
A. No, he's a good guy.
Q. All right. At some point, you've testified, that you reviewed the electronic medical record; is that correct?
A. Yes.
Q. As you were reviewing the electronic medical record did more memories pop into your head regarding the matter?
A. Yes.
Q. Okay. Do you know who was the first doctor -- you may not know. If you don't know, by the way, please say I don't know. Do you know who was the first doctor at McLaren to work on Ms. McLain that night, February 7th, 2008?
A. Yes.
Q. Who was that person?
A. I'm blanking on his name. It's Heights or -- he's a -- I'm blanking.
Q. Was it a resident?
A. He was a resident.

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Q. Could it have been Dr. Jason Henney?
A. Jason Henney, yeah.
Q. Okay. And given that I'm certainly no expert on the chain of command in a hospital, if my question here sounds ignorant I apologize. Were you as the full-fledged doctor somehow a supervisor of Dr. Henney as a resident or that's not how it works?
A. No, as a matter of fact I came on later on in that case. One of my associates is the one that took care of her for the first two days.
Q. Okay. So you didn't come on the case say until the 9th of February; is that accurate?
A. Yes.
Q. All right. I am about to give you, as soon as I show to counsel, an e-mail.
This has been seen by you and Dave before, but before I introduce it I always like to give you the respect to look at it?
MS. FOLINO: Sure.
MR. ROSENBERG: Okay. Here's a copy for you.
This is going to be marked as Exhibit 1.
BY MR. ROSENBERG:
Q. Doctor, I'm going to ask you to look at this e-mail, please read it in its entirety, don't rush, let me

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know when you're done.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 1
10:34 a.m.
A. Okay.
BY MR. ROSENBERG:
Q. *Okay. Have you had a chance to read the document?*
A. Yep, I'll talk to him about his grammar.
Q. It appears this document, which is Exhibit 1, is an e-mail from Dr. Justin Kisaka, K-I-S-A-K-A, to myself on June 28th. Dr. Kowalczyk, is it accurate when Dr. Kisaka states Ms. McLain was seen and followed by my associate, Dr. Michael Kowalczyk, a board-certified internal-medicine physician, is that an accurate statement in your opinion?
A. Yes, the only thing he -- Dr. Bajpai was the one who was on when she was admitted.
Q. *Would you be able to spell that for me, please?*
A. B-A-J-P-A-I.
Q. B-A-J-P-A-I. You wouldn't know a first name, would you?
A. V-I-K-A-S.
Q. So you believe that Dr. Bajpai --
A. Well, I know Dr. -- I looked at the records and Dr. Bajpai had written notes the first two days that

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she was there.
Q. *Would he be referred to as a -- is that a he or a she,* I'm sorry?
A. It's a he.
Q. Would he be referred to as a hospitalist or you don't -- wouldn't know his credentials?
A. No, like our -- he was part of our group and he provides -- our group provides hospital coverage for the --
Q. Okay. All right. Is he still a member of your group at this time?
A. No, he is not.
Q. Okay. I'm assuming if we asked you in writing, not at this deposition but follow up with you in writing to provide his last known address you'd be able to do *that for us?*
A. I could find it, probably.
Q. I'd appreciate that. Were you able to discern from the chart who it was who reintubated Ms. McLain on February 7th, 2009?
A. Yes, Dr. Henney.
Q. Dr. Jason Henney. And again, I understand you're relying on the chart, I understand that.
A. Right, and he would be under the supervision, to go back to your -- of the emergency-room physician,

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who -- I'm not sure who the attending emergency-room physician was.
Q. Well, that -- I'm glad you bring that up because you've moved about -- to the next question I have. Back to Exhibit 1, the -- when I look in the medical chart, and again, I realize you weren't there the first night, but just for setting up a record do you have some familiarity with how Ingham Regional, now McLaren, sets up its records in terms of what it shows and a history and a physical, have you had some familiarity with those records through the years?
A. Yes.
Q. Those records have indicated that the attending was Dr. Justin S. Kisaka, which is why we sent a subpoena to Dr. Kisaka and then Dr. Kisaka says he never viewed the patient --
A. Right.
Q. -- is that possible?
A. Yes.
Q. Okay. When you say that Dr. Henney to your knowledge *was under the supervision, would that be Dr. Kisaka* who would have --
A. No.
Q. -- supervised him?
Okay. Who would have -- to your knowledge

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who would have supervised Dr. Henney?
A. One of the emergency-room attendings. Dr. Henney was an emergency-room resident.
Q. Okay. All right. So that emergency-room attending is *different than the attending listed in this record as* Justin S. Kisaka?
A. Yes.
Q. Okay, got it. Thank you very much. Is intubation something to your knowledge at Ingham Regional that residents sometimes do?
A. Yes.
Q. Okay. I'm aware that Dr. Henney has subsequently departed the hospital when his residency was done, but when he was a resident did you personally, Doctor, have any work experience with Dr. Henney in any *patient matters?*
A. Yes.
Q. Okay. Is he someone you worked with fairly often or not really?
A. Not really.
Q. How many times do you think you might have interacted with him say in a year, I'm just trying to get a feel for your knowledge of Dr. Henney?
A. I mean, during his internship it would have been fairly regular if he was doing an internal-medicine

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rotation. I can't remember how many rotations he did, but he was a very competent physician.

Q. Did you ever have any reason to reprimand him or scold him?

A. No, he was a very good physician.

Q. Do you need to take that?

A. *Do you mind if I take a call here?*

MR. ROSENBERG: We're off the record, it's all yours, take all the time you need.

(Discussion off the record at 10:40 a.m.)

(Back on the record at 10:41 a.m.)

BY MR. ROSENBERG:

Q. Okay. So Dr. Henney was a very competent physician, you said never had any reason to reprimand him. To your knowledge based on what you know did anyone in your practice, your private practice, ever bring any complaints about Dr. Henney to you?

A. No.

Q. Okay. So you're -- and I'm not tying you to the hour, but given that in the evening of February 7th Ms. McLain presented via ambulance to the hospital, you didn't become involved until a couple of days later?

A. Correct.

Q. Once you got involved did you have any to your

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recollection conversations with folks who had been treating her from the beginning, whether it was Dr. Bajpai or Dr. Henney or anybody else?

A. Well, Dr. Bajpai, certainly, but I can't recall anybody else.

Q. Okay. Do you recall what Dr. Bajpai told you?

A. Just that she had -- they thought that she had been -- like her esophagus had been intubated and they were worried about an anoxic event to her brain.

Q. I'm sorry, the last piece of that?

A. Anoxic event to her brain.

Q. Okay. Just for clarity sake, when Dr. Bajpai was worried that the esophagus had been intubated was he --

MS. FOLINO: I'll object to the form.

Go ahead, I didn't mean to interrupt you.

MR. ROSENBERG: Don't worry about it, don't worry about it, Counsel, your objection is noted.

BY MR. ROSENBERG:

Q. With regard to that, did Dr. Bajpai mention whether this occurred at the hospital, in an ambulance or somewhere else, and if so where?

A. Well, they thought it was probably prior to the hospital.

Q. Okay. Did you ever have any concern about the

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professional competency of Dr. Bajpai?

A. No.

Q. Would you consider Bajpai to be a competent doctor?

A. Yes.

Q. Okay. You became involved with the treatment of Ms. McLain a couple days later. What did you -- and I realize the patient was at the end of her life, what did -- what was your involvement in terms of treating Ms. McLain?

A. *To provide medical management in conjunction with the other subspecialists; the pulmonary, the infectious disease, the neurologists.*

Q. Okay. Have you yourself intubated people before?

A. Yes.

Q. Any idea how many you've intubated?

A. No idea.

Q. More than five?

A. Yes.

Q. Okay. More than ten?

A. Yes.

Q. *I won't ask for anymore numbers, thank you.* When you intubate someone -- and I realize you didn't intubate this patient, I got that, I'm just talking to you as a physician and asking you a question.

When you intubate someone -- or maybe

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better put when in 2009 you would have intubated someone what were some of the checks that you used to see if an intubation was done properly?

A. You listen for breath sounds and in the hospital setting you can check the carbon dioxide.

Q. Okay. What else?

A. You can look for -- to see if there's moisture in the ET tube that changes with breaths.

Q. Okay. Anything else?

A. No, I mean, in the hospital setting you verify with x-ray placement.

Q. Fair enough, okay. But obviously that wouldn't apply to an ambulance, there's no x-ray to do that most likely, okay. In this Exhibit 1, by the way, that I put back in front of you is there anything that to your knowledge Dr. Kisaka wrote that's just false, anything that you believe not to be true in that -- in that Exhibit 1?

A. No, he just left out Dr. Bajpai.

Q. Okay, thank you. Joel Post, do you know who Joel Post is?

A. Yes.

Q. Who is Joel Post?

A. He is -- he was an intern back then, he's an orthopedic resident right now.

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Q. Okay. Have you done any work with Dr. Post?
A. Yes.
Q. Do you consider him to be a competent physician?
A. He is very competent.
Q. You said very competent?
A. Very, he's -- I think he has a fellowship at Mayo Clinic.
Q. Okay. Ever known Dr. Henney not to be a truthful person?
A. No.
Q. Ever known Dr. Post to not be a truthful person?
A. No.
Q. Okay.

MS. FOLINO: Let me object to the form.

MR. ROSENBERG: No problem, objection noted, answer received.

BY MR. ROSENBERG:

Q. Did Dr. Bajpai ever opine to you on what the result would have been had the intubation not been in the esophagus?
A. No, I can't recall.
Q. Did you ever form an opinion that you can recall on that matter regarding Mrs. McLain?
A. I mean, you know, theoretically you would think that she would have not had a hypoxic event like that so --

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Q. Okay.
A. She did have bad asthma though, but that's hard to say.

MS. FOLINO: I didn't hear the answer, Doctor, I'm sorry?

A. I mean, you know, theoretically you would think that if she didn't have the anoxic event then she wouldn't have suffered the cerebral death, but she did have very bad asthma too. It took a couple days to break her asthma.

BY MR. ROSENBERG:

Q. When you say a couple days to break her asthma, for those of us who are laymen, help me out, what does that mean?
A. She just had a lot of bronchospasm going on.
Q. Okay. All right. To your recollection did Mr. McLain, that being the husband of Ms. McLain, did he ever act inappropriately in the hospital to you?
A. No.
Q. Did he ask you what you thought went wrong with regard to his wife's condition?
A. Well, we tried to explain things, you know, how we theorized -- the theories we had on what happened.
Q. And did that include the issue of an intubation in the esophagus?

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A. Probably.
Q. Okay. But you don't remember for certain?
A. I can't remember, it probably had.
Q. Okay. Were you Ms. McLain's physician at the time of the end of her life or --
A. Yes.
Q. Just a moment, please. Doctor, have you ever heard of a scenario to your knowledge where an intubation is done properly but someone has just moved out of an ambulance and somehow the intubation moved into the esophagus, have you ever heard of a story and confirmed one like that?
A. No.
Q. Okay. Dr. Henney -- strike the question.

Have you ever been involved with treating -- Doctor, forgive that, try one more time.

Have you ever been involved with training interns and residents at McLaren, formerly Ingham Regional?
A. Yes.
Q. To your knowledge are such individuals trained that if there's a problem with an intubation it should be fixed promptly?
A. Yes.
Q. Does it happen sometimes that intubations are not put

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in the first time so they have to be taken out and put back in?
A. Yes.

MS. FOLINO: Objection.

MR. ROSENBERG: Objection noted, answer gotten.

Doctor, I have no further questions, I appreciate your time. I'm sure Ms. Folino will have some, I may have a few follow up, but I appreciate your time this morning.

EXAMINATION

BY MS. FOLINO:

Q. Doctor, I'm Anita Folino, we met before the deposition and I represent the City of Lansing and Jeffrey Williams and Michael Demps, who are EMTs who work for the City of Lansing. If at any time you don't know what I'm asking, let me know and I'll try to rephrase.

I'm going to start maybe backwards a little bit and work forward. You indicated that Ms. McLain had severe asthma, right?
A. Yeah, she had a history of it per her husband and the medical record.
Q. And when she came to you what was the state of her asthma?
A. She was having a very severe asthma attack.

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Q. Was it like a status --
A. Status asthmaticus, yes.
Q. Which is the worst asthma you can have?
A. Yes.
Q. Okay. In those cases -- and I'm going to say this in a layman kind of way, okay? The problem with the breathing is way deep in the lungs, right, it's not up in the esophagus -- or not the esophagus. It's not up in the larynx, it's not high in the airway, it's way deep in the lung with the exchange of air; is that right?
A. Yes.
Q. Okay. So what happens up high in the airway can have nothing to do with the ability of this lady to exchange oxygen and carbon dioxide, is that a fair, very simplistic statement?
MR. ROSENBERG: Objection; form, foundation.
You can answer.
A. That's -- yep, yep, that's -- that's true.
BY MS. FOLINO:
Q. That's true, correct?
A. Yes, uh-huh.
Q. And you have -- have you in your treatment of patients in the intensive-care unit seen people die because

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there's an inability to either be able to even on a respiratory, through volume control or pressure control get the proper exchange of oxygen and carbon dioxide; in other words, make their lungs work when they're in status asthmaticus?
MR. ROSENBERG: Objection; form, foundation, compound question.
You can answer, if you can.
BY MS. FOLINO:
Q. Do you want me to make it a little easier?
A. No, I mean, I can't recall any specific events like that, but, I mean, we've had asthmatics.
Q. All right. Is that a possibility?
A. Yes.
Q. Okay.
MR. ROSENBERG: The same objections.
BY MS. FOLINO:
Q. Is that known in the medical literature?
A. Yes.
Q. Okay. And also is it known in the medical literature that if you cannot in a medical setting get this exchange of air and carbon dioxide correct that brain damage will occur --
MR. ROSENBERG: Form -- I'm sorry.
BY MS. FOLINO:

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Q. -- called anoxia?
A. Yes.
MR. ROSENBERG: Objection -- before we go on, objection; form, foundation, compound question and frankly I think counsel is testifying, but the answer is noted.
BY MS. FOLINO:
Q. Okay. You don't have any firsthand knowledge of how long this lady was down in the field, correct?
A. No, I don't.
Q. Okay.
A. I was rather surprised that in the EMR that said there -- it -- they mentioned five minutes, which --
Q. Go ahead.
A. I was just kind of surprised that they only mentioned -- like they thought -- they estimated five minutes in there.
Q. Okay. Do you know who estimated five minutes?
A. It was Dr. Henney's --
Q. Okay. Do you know from where Dr. Henney got that information?
A. No.
Q. Okay. Now, did you ever read the EMT report, the transfer report?
A. I can't -- I did, but I can't recall it right now.

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Q. Okay. If -- assume that the EMTs testified they had breath sounds and assume their report notes that they had chest movement, they were listening and they noted chest movement, breath sounds on the trip after intubation. If that had been in the esophagus for five minutes would you expect any sign of esophageal intubation when the patient got to the hospital?
MR. ROSENBERG: Objection; form, foundation, assumes facts not in evidence.
You can answer.
A. You'd expect their abdomen to be very distended because of the air that's going into there.
BY MS. FOLINO:
Q. Okay. I want to show you, Doctor, what is the medical record for the emergency physician, cardiopulmonary resuscitation, and this is an emergency record 2-7-09, room 1, and see that right there and I have highlighted under abdomen and it says distension?
A. Yeah.
Q. Is it marked?
A. No.
Q. Okay. Look through that emergency-room record and see if you can see anywhere where anyone has noted abdominal distension?
A. No, no.

Q. Okay. You never yourself, Doctor, talked to any of the EMTs or the rescue folks?
A. No.
Q. Did you ever receive any kind of an account of what happened in transport to the hospital from Mr. McLain?
A. No.
MS. FOLINO: Okay. I don't have anything else, thank you, Doctor.
RE-EXAMINATION
BY MR. ROSENBERG:
Q. I have a few and I won't keep you long.
You said before -- and again, if I mischaracterize, it's a mistake. I think you testified you were a little surprised when you saw the estimate of five minutes, did I understand you correctly?
A. Yes.
Q. Can you share with us why you were surprised?
A. I mean, sometimes we have people that are down longer than that that have complete recovery, although theoretically, you know, more than -- I mean, that amount of time you're going to have a good degree of brain damage.
Q. Okay. Is it possible in your professional opinion that Dr. Henney was estimating when he said five

minutes?
MS. FOLINO: Objection to foundation and form.
BY MR. ROSENBERG:
Q. You can answer.
A. Yeah, I mean, anything is possible.
Q. Okay. Well, how does one and -- how does one, in layman's terms if it can be done, estimate how long a patient has been down, so to speak, again, if you can put it into layman's terms that would be great because I won't understand the medical ones?
A. Well, you look at what time that the -- you had to start the CPR, they weren't breathing, until what time you resuscitate them or start CPR.
Q. Okay. All right. Is it possible, Doctor, that the asthma would have been in an ameliorated state had the intubation been done properly in the beginning, is that possible?
A. No, I don't think so.
Q. You don't think they're related at all?
A. No.
Q. All right. But to your -- I'm sorry?
A. Well, I mean, it sounds like she had been intubated a few times. She's a very, very bad asthmatic.
Q. Okay. But, again, you're not stating that the asthma

caused the brain damage, you're testifying that the asthma was just a bad case and had -- and it was an issue for you --
A. I mean, I don't know if she -- she had a bad case of asthma, she did.
Q. Okay.
A. I don't know --
Q. All right. If somebody is intubated properly and has -- has been reintubated and it's proper, wouldn't any distension in the abdomen go down once the intubation was done correctly?
A. No, you'd have to put an NG tube down to decompress the stomach, it wouldn't just spontaneously --
Q. Okay. Are there ever events or things that go on with the patient that may not get noted immediately in the chart or noted in the chart?
A. Sure.
Q. Okay. Does weight have any effect on stomach distension?
A. It makes it more difficult to estimate it.
Q. Okay. In other words, the more weight there is the relatively more difficult it can be to estimate?
A. Yes.
MR. ROSENBERG: Okay. No further questions, Doctor.

MS. FOLINO: I have nothing further.
(The deposition was concluded at 11:03 a.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF OAKLAND)

I, BECKY JOHNSON, certify that this deposition was taken before me on the date hereinbefore set forth; that the foregoing questions and answers were recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to, either party nor interested in the event of this cause.

BECKY JOHNSON, CSR-5395
Notary Public,
Oakland County, Michigan
My Commission expires: January 28, 2013

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)

) SS

COUNTY OF OAKLAND)

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Becky Johnson

BECKY L. JOHNSON, CSR-5395

Notary Public,

Oakland County, Michigan

My Commission expires: January 28, 2013

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Eric J. Rosenberg

From: JUSTIN KISAKA [saskyjust@msn.com]
Sent: Thursday, June 28, 2012 11:49 PM
To: Eric J. Rosenberg
Subject: Deposition

Dear mr Rosenberg,

as I stated during our conversation I can not comment on Tracy McLain's case since I never saw this patient. As it is customary for our practice and many other practices,all patients who were admitted while I was on call were admitted under my name. Ms MClain was seen and followed by my associate Dr Michael Kowalczyk,a board certified internal medicine physician. I was never involved in her care. I would be more than happy to testify on this case, but unfortunately I will be of no help to your client since I will simply state the truth, which is that I can not comment on the case because I was never involved in ms McLain's case.

Thanks.

Sincerely

Dr Justin S Kisaka DO